MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11076

469

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? nine years, 5 mos., 23 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 9 years, 5 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: MINNIE ABRAMS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): (unknown) ABT. 1891

8. AGE: Years	Months	Days	If less than one day
57?	--	--	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville State Hospital

17. Burial, cremation, or removal. Which? burial Date thereof: 11/29-48 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt. Hospt.
Address: Crownsville Md

19. 11/29 - 1948 E F Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 1948 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1939 to November 19, 1948 and that I last saw her alive on November 19, 1948

Immediate cause of death	DURATION
Schizophrenic reaction	known to us for 3 months
Cancer of Pancreas	
Due to	
Due to	known to us since 5-17-39
Other conditions Probable cancer of Stomach	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. ---
Autopsy results: ---
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Jacob Trapnell M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 11/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11077

83a

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Behind Katzinis store - west St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 26 Calvert St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Allsup

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 19 1907

8. AGE: Years	Months	Days	If less than one day
41	4	—	____ hrs. ____ min.

9. Birthplace: ANNAPOLIS, MARYLAND (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business: NONE

FATHER — 12. Name: THOMAS ALSOP

FATHER — 13. Birthplace: ANNAPOLIS

MOTHER — 14. Maiden name: ANNIE QUEEN

MOTHER — 15. Birthplace: ANNAPOLIS, MARYLAND

16. Informant: Helen Ricks

Address: 58 Clay Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-1948 (month) (day) (year)

Cemetery or crematory: [redacted] Asbury

Location: [redacted] Smithville

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Nov. 23 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21 1948, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased~~ from ____ 19____, to ____ 19____ and ~~that I last saw him~~ alive on ____ 19____

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. (M.D. or other)

Address: Annapolis, Md. Date signed 11/24/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11078

940

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mulberry Hill near Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 Years
Hospital, institution, or street address where death occurred: Mulberry Hill near Annapolis
How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Mulberry Hill near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mulberry Hill near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: Grafton Duvall Anderson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Bertha Anderson ---------- --- -
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): June 6, 1891

8. AGE: Years	Months	Days	If less than one day
57	5	3	....hrs. ....min.

9. Birthplace: Browns Woods A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: None

FATHER
12. Name: Matthew Anderson
13. Birthplace: St. Margrets A.A. Co. Md.

MOTHER
14. Maiden name: Mary Kathrine Stansbury
15. Birthplace: Kent Island, Eastern Shore, Md.

16. Informant: Bertha Anderson
Address: Mulberry Hill A.A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11- 12- 1948 (month) (day) (year)
Cemetery or crematory: Broad Neck Cemetery
Location: St. Margrets ----- --near Annapolis

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Nov. 12 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/9 1948, at 9 35P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/9 1948 to 11/9 1948
and that I last saw h[illegible] alive on 11/9/48 1948

Immediate cause of death	DURATION
Coronary Insufficency	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Theodore K. Johnson M.D.
M. D. or other
Address: 40 Northwest Street Annapolis, Md. Date signed 11/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr Basel

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

52b

11679

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1038 Bowden Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert F. Atwell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Bertha M. Atwell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 16th 1878

8. AGE: Years 70 | Months 9 | Days 23 | If less than one day: hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)

10. Usual occupation: Boat Builder - Carpenter

11. Industry or business

FATHER — 12. Name: Robert F. Atwell

13. Birthplace: A A Co Md.

MOTHER — 14. Maiden name: Minnie Kirchner

15. Birthplace: A A Co Md.

16. Informant: Bertha M. Atwell

Address: 1038 Bowden Ave Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-11-48 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial

Location: Glen Burnie A A Co Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. 11/11/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 1948 at 11a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 8 1948, to Nov 8 1948 and that I last saw h[illegible] alive on Nov 8 1948

Immediate cause of death	DURATION
Carcinoma of Bladder	Several Months
Due to	
Due to	
Other conditions Arteriosclerosis	Several Years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Basil M. D. or other

Address: Annapolis Md. Date signed 11-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 11080

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Linthicum (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 803 Camp Meade Rd.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anundel Co.

City or town Linthicum (If outside city or town limits, write RURAL and give nearest town)

Street No. 803 - S. Camp Meade Rd. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Willis Philip Ballard.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widower

6.(b) Name of husband or wife Willie Cun —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 12 - 1851

8. AGE: Years 97 | Months 3 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Va - Allemarle Co. (Town, county, and state)

10. Usual occupation Farmer -

11. Industry or business

FATHER — 12. Name Wm P. Ballard -

13. Birthplace Va

MOTHER — 14. Maiden name Nancy Via

15. Birthplace Va

16. Informant N.K. Ballard

Address 213 - Todd ave. Charlottsville

17. Burial, cremation, or removal. Which?) Burial Nov. 16 - 48 Date thereof 11/16/48 (month) (day) (year)

Cemetery or crematory Mt. Maria Cemetery

Location White Hall Va

18. Funeral director Wm D. Ingram & Co.

Address River dale - md

19. Nov 13 1948 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1948 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 45 to Nov. 13 1948 and that I last saw h alive on Nov. 13 1948

Immediate cause of death	DURATION
Cardio - Vascular Disease	3 days.
Due to	
Due to	
Other conditions Bronchial Asthma	10 yr.

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Chas L. Ball Jr MD M. D. or other

Address Linthicum Date signed 11-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 11081

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? --- D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 25 Dean St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: LILLIAN BLAY

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Neil Blay
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1881

8. AGE:

Years	Months	Days	If less than one day
67	7	3	..... hrs. ..... min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business: ---

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Papers of Mrs Lillian Blay
Address: 25 Dean St. Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5, 1948 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Mafyland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Nov. 5, 1948 (Date rec'd by registrar) J. D. Brinck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 2 1948, at 1-00 P.M.

21. I CERTIFY that death occurred on the date above stated, ~~to the best of my knowledge~~ Post mortem Examination Nov. 2, 1948.

	DURATION
Immediate cause of death	
Cerebral accident	sudden
Due to: Arterio-sclerosis (general)	unknown
Due to: Arterial Hypertension	unknown
Other conditions	

(Include pregnency within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. of other
Address: Annapolis, Md. Date signed 11-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for correction of spelling of given name shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

11082

93d

FILM No. G 118 DEC - 3 1948 CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural - Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: Home - Farm of Joseph Bottner
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural - Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Farm of Joseph Bottner
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: KRESZENZ ~~Hyacinth~~ Bottner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	~~W~~ S

6.(b) Name of husband or wife: Read

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 17, 1857

8. AGE: Years	Months	Days	If less than one day
91	4	11	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: (Retired) Housekeeping

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: " "

MOTHER
14. Maiden name: Unknown
15. Birthplace: " "

16. Informant: Joseph Bottner
Address: Gambrills post office Maryland

17. Burial (Burial, cremation, or removal—which?) Date thereof Nov 30/48 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Annapolis Md.

18. Funeral director: B. H. Hopkins & Son
Address: Annapolis Md.

19. Nov. 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28 1948, at 10 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1948, to Nov-28 1948
and that I last saw h er alive on Nov - 16 1948

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Arteriosclerotic cardio -	
Due to: vascular disease -	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D.
M. D. or other
Address: Annapolis, Md. Date signed: Nov. 28, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95c

Reg. Dist. No. 11083

1. PLACE OF DEATH:
County Anne Arundel
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Carlton Manor
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Same
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Nora Blanche Broseker

3. (b) Social Security Number

4. Sex F.
5. Color or race W.
6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband ~~or wife~~ Roland Broseker
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) June 19 - 1890

8. AGE: Years 58 Months 4 Days 13 If less than one day ...hrs. ...min.

9. Birthplace Brooklyn, Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Joseph T. Ward
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden name Marley Watson
15. Birthplace Anne Arundel Co. Md.

16. Informant Mr. Roland Broseker
Address Severna Park. Md.

17. B (Burial, cremation, or removal (which?)) Date thereof 11-5-48 (month) (day) (year)
Cemetery or crematory Crossroads Cem.
Location Millersville Md
18. Funeral director J. L. McCealy
Address 150 P. Fort Ave.

19. 11/5 19 48 A.W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 1948 at Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1947, to October 30 1948
and that I last saw her alive on 10/30/48 19

	DURATION
Immediate cause of death Coronary disease	2 years.
Due to Enlargement of the heart	2 years.
Due to Pulmonary Edema.	2 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? No (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Fauber M.D. M. D. or other
Address Glen Burnie, Md Date signed 11/2/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11084

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.

County

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 18 Lafayette Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 18 Lafayette Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hattie Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles Brown

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 2, 1901

8. AGE: Years	Months	Days	If less than one day
47	4	18	...hrs. ...min.

9. Birthplace: Skidmore, A.A.Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Alton Johnson
13. Birthplace: Skidmore, A.A.Co. Maryland

MOTHER
14. Maiden name: Lillian Colbert
15. Birthplace: Skidmore A.A.Co. Maryland

16. Informant: Charles Brown
Address: 18 Lafayette Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11- 24- 1948 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Nov. 28 1948 (Date rec'd by registrar)

W. D. Branch
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1948 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Only on Nov. 20, 1948 to ... 19..

and that I last saw h... alive on ... 19..

	DURATION
Immediate cause of death: Cerebral Hemorrhage	12 hr.
Due to: Arterial Hypertension	3 hrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: R. F. Richardson M.D.
M. D. or other

Address: 110 - Clay St., Annapolis Md. Date signed 11/29/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11086

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos. 20 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 8 mos. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4649 Falls Road

(If rural, give LOCATION)

2.(a) If veteran, name war: ----

3. (a) FULL NAME: JOHN BROWN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Divorced

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE:	Years	Months	Days	If less than one day
	58			....hrs. ....min.

9. Birthplace: Howard County, Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ----

FATHER — 12. Name: John Brown

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rebecca Brown

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-23-48 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Cedar Hill Md.

18. Funeral director: Isaac Jones Halstead

Address: 918 Druid Hill Ave.

19. Nov. 22 1948 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 1948, at 7:49 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27 1948, to November 17 1948 and that I last saw him alive on November 17 1948

Immediate cause of death: Chronic Myocarditis — known to us since — DURATION: July 1948

Due to: ....

Due to: ....

Other conditions: Senile Psychosis — known to us since — 2/27/48

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op. -----

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of ----

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury: ----- Injured at work? ---

23. SIGNATURE: Jacob Mungenstein M.D.

Address: Crownsville, Md. M. D. or other

Date signed: 11/17/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Be 11085

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 8 mo. 15 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 5 yrs. 8 mo. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1421 East Fayette Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

MARY ANN BROWN (MARIE) #5

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): about 1891

8. AGE: Years	Months	Days	If less than one day
57? --	--	--	hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Maid

11. Industry or business: ----

FATHER

12. Name: John Morgan

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sarah Briscoe

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/18-48 (month) (day) (year)

Cemetery or ~~crematory~~: Hospital.

Location: Crownsville Md

18. Funeral director: Dept Hospitals

Address: Crownsville Md

19. 11/18 48 E. Joyce Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1948, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26, 1943 to November 11 1948 and that I last saw her alive on November 11, 1948

Immediate cause of death	DURATION
Uremia	
known to us since	2/26/43
Due to	
Due to	
Other conditions: General Paresis	
known to us since	2/26/48

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op. -------

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of -----

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury: ----- Injured at work? -----

23. SIGNATURE: Jacob Marquette M.D.

M. D. or other

Address: Crownsville, Md. Date signed 11/11/48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11087

61

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A. A.

City or town: St. Margretts

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: St. Margretta

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Irene Butler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widow

6.(b) Name of husband or wife: Morris Butler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 18th 1892

8. AGE: Years	Months	Days	If less than one day
56		12	..... hrs. ..... min.

9. Birthplace: St. Margretts A. A. Co.

(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: George Kenan

13. Birthplace: A. A. Co.

MOTHER 14. Maiden name: Mary E. Fleetwood

15. Birthplace: A. A. Co.

16. Informant: Margretta Butler

Address: St Margretta

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 13 1948 (month) (day) (year)

Cemetery or crematory: Kenans family Cem.

Location: St Margretta A. A. Co.

18. Funeral director: J. B. Lamar

Address: Centreville

19. Nov. 12 48 (Date rec'd by registrar) — O. Church Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 10th 1948, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1st 1948, to Nov 10th 1948

and that I last saw her alive on Nov 9th 1948

Immediate cause of death	DURATION
respiratory failure	
Due to: hypertension	
Due to: Diabetes	
Other conditions: Neoplasm of pancreas	

(Include pregnancy within 3 months of death)

Major findings of operations: tumor of pancreas

Anna. Hosp. Date of op. 1942

Autopsy results: not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edith Rudler M.D.

M. D. or other

Address: 42 State Circle, Annapolis Date signed: 11-12-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11088

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Birdsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Campfield

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widowed

6.(b) Name of husband or wife: Elizabeth Carroll

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 4. 1877

8. AGE:

Years	Months	Days	If less than one day
71	8	5	hrs. min.

9. Birthplace: West River Md (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER

12. Name: J. Campfield

13. Birthplace: Unknown

MOTHER

14. Maiden name: Fannie Carroll

15. Birthplace: Unknown

16. Informant: Sam'l Segal

Address: Cumberstone Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 1948 (month) (day) (year)

Cemetery or crematory: Catholic Cem Owensville Md

Location: Owensville Md

18. Funeral director: F. A. Handley & Son

Address: Galesville Md

19. 11 11 1948 (Date rec'd by registrar)

J. D. Council Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 1948, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5, 1948, to Nov. 9 1948 and that I last saw him alive on Nov. 9 1948

Immediate cause of death	DURATION
Bronchopneumonia	
Due to: arterio - arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Emily H Wilson, M.D. M. D. or other

Address: Lothian, Md. Date signed 11-9-48

EVIDENCE FOR CHANGE OF ITEM #6. SHOULD ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11089

932

FILM No. G 118 DEC 15 1948

Reg. Dist. No. 26

M

1. PLACE OF DEATH:

County Anne Arundel

City or town Linthicum Hgts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

Main Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Linthicium Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Battista G. Carecchio

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	SEPARATED

6.(b) Name of husband or wife Catherina

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 2. 1875

8. AGE: Years	Months	Days	If less than one day
73	10	8	hrs. min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Jack Carecchio

13. Birthplace Italy

MOTHER 14. Maiden name Mary Persone

15. Birthplace Italy

16. Informant Martin Torrero

Address Linthicum

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/13/48 (month) (day) (year)

Cemetery or crematory Holy Redeemer Cemetery

Location Baltimore, Maryland

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul Street

19. 11-10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 (9) 1948, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15 1948, to Nov. 10 1948

and that I last saw h— alive on Nov. 10 1948

Immediate cause of death	DURATION
Cardio-Vascular-Disease	Aug. 48
Due to	
Due to	
Other conditions Arterio-sclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. MD

M. D. or other

Address Linthicum Date signed 11-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11090

552

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
2 N. Cherry Grove Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2 N. Cherry Grove Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Howard W. Christy Sr.

3.(b) Social Security Number: 214-05-0215

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married.
6.(b) Name of husband or wife: Bertha E. Christy
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): July 10th 1892
8. AGE: Years: 56 Months: 4 Days: 10 If less than one day: ____ hrs. ____ min.
9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: Manager American Oil Co.
11. Industry or business: Annapolis Maryland

FATHER
12. Name: Thomas Henry Christy
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Amelia E. Fogel
15. Birthplace: Maryland

16. Informant: Mrs. Bertha E. Christy
Address: 2 N. Cherry Grove Ave. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24 1948 (month) (day) (year)
Cemetery or crematory: Western Cemetery
Location: Baltimore Md.

18. Funeral director: John M. Jay Co. Inc.
Address: Annapolis Md.

19. Nov 23 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20th 1948, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1. 1948 to Nov 20 1948
and that I last saw h. alive on Nov 20 1948

	DURATION
Immediate cause of death: Myeloma (Multiple)	Several
Due to: Lytic lesions Cranial bones ribs & pelvis	Months
Due to:	
Other conditions: Pontonemus fracture	2 wks
(Include pregnancy within 3 months of death)	

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George B. Beard M. D. or other
Address: Annapolis Md Date signed: 11-22-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a 11091

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. (Bedencville)
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Henry Simons Crozier

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Lillie Jane Thacker
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): May 27, 1872 ?

8. AGE: Years	Months	Days	If less than one day
76?			hrs. min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: ----Crozier
13. Birthplace: Georgia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Georgia

16. Informant: Mary N. Pickles
Address: 711 Longfellow St. N.W.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 11/17/48 (month) (day) (year)
Cemetery or crematory
Location: Rome, Georgia
18. Funeral director: Wm. L. Stidham Company
Address: 2901 14th St. N.W.

19. 11/18 19.48 (Date rec'd by registrar) L. J. Deach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 19.48 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19.48, to Nov. 16 19.48 and that I last saw h. alive on Nov. 12 19.48

Immediate cause of death	DURATION
Mitral Insufficiency	+2½ months
Due to: Enlarged heart	4
Due to: Interstitial nephritis	1
Other conditions: General arteriosclerosis	1

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Gustave A. Paulsen M.D. M. D. or other
Address: Glen Burnie Md. Date signed: 11/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 11092

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Annapolis md Parole

(If outside city or town limits, write RURAL and give nearest town)

Street No. /

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles E. Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

8.(b) Name of husband or wife Sarah Dorsey

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 1, 1897

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
51	6	2		

9. Birthplace Chesterfield md.
(Town, county, and state)

10. Usual occupation Cook.

11. Industry or business

FATHER 12. Name Abraham Dorsey

13. Birthplace md.

MOTHER 14. Maiden name Mary Betters

15. Birthplace md.

16. Informant Alice Blake

Address Parole, md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1948 (month) (day) (year)

Cemetery or crematory Davidsonville Cemetery

Location Davidsonville, md

18. Funeral director J. B. Johnson

Address Annapolis, Md. P. O. Box 462

19. Nov 5 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1948, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/3 1948, to 11/3 1948

and that I last saw h. 1m alive on November 3m 1948

Immediate cause of death	DURATION
Coronary Thrombosis	2hr
Due to Coronary Occlusion	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE Theodore G. Johnson M.D.
M. D. or other

Address 40 Northwest Street Date signed 11/5/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 11293

Reg. Diat. No.

1. PLACE OF DEATH:
County Greenland Beach
City or town A. A. Co.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. Greenland Beach
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ETHEL LEONA DOXEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Wm. H.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 2 - 1894

8. AGE: Years 54 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER
12. Name: Wm. Jackson
13. Birthplace: Md

MOTHER
14. Maiden name
15. Birthplace: Md

16. Informant: George E. Doxen
Address: Greenland Beach Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30th 1948 (month) (day) (year)
Cemetery or crematory: Morlands
Location: Taylor Ave

18. Funeral director: Leo G. Cook
Address: 1701-03 N. Patterson Park Ave

19. Nov 29 1948 (Date rec'd by registrar) O. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1948, at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 22 1948 to Nov 28 1948 and that I last saw h. ER alive on Nov. 27 1948

Immediate cause of death	DURATION
HEART FAILURE	
Due to: Cerebral Hemorrhage	1 week
Due to: Broncho-pneumonia	1 week
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other
Address: Riviera Beach, Md. Date signed 11/28/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 21 11094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2Hours
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 2 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Lothian A.A. CO. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lothian A. A. CO. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY LOU EVANS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: William Evans
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): January 1, 1889

8. AGE: Years	Months	Days	If less than one day
59	11	4	____ hrs. ____ min.

9. Birthplace: Lothian A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Midwife
11. Industry or business: None

FATHER
12. Name: Mike Wallace
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden name: Harried
15. Birthplace: Lothian A.A.Co. Md.

16. Informant: Agnes Brandford
Address: 49 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11- 9- 1948 (month) (day) (year)
Cemetery or crematory: Moses Cemetery
Location: Drury A.A. Co. Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Nov. 9 1948 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5 1948 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1948, to Nov. 5 1948
and that I last saw h... alive on Nov. 5 1948

Immediate cause of death	DURATION
acute myocarditis	
Due to Diabetes mellitus	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. (M. D. or other)
Address: Lothian, Md. Date signed: 11/7/48

11695

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 518

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yrs
Hospital, institution, or street address where death occurred:
Crownsville, Rd. off Defence Hy
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis RFD # 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOSEPH S. FISCHER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary A. Fischer
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Feb 20, 1878

8. AGE: Years	Months	Days	If less than one day
70	9	0	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farming

FATHER
12. Name: Frederick Fischer
13. Birthplace: Germany

MOTHER
14. Maiden name: Rohr
15. Birthplace: Baltimore, Maryland

16. Informant: Mr. Bernard J. Fischer (Son)
Address: RFD #1 Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11- 23- 48 (month) (day) (year)
Cemetery or crematory: Our Lady of The Fields
Location: Millersville, A.A. Co. Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Nov. 21 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 20 1948, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Nov 20 1948.
and that I last saw h... alive on Nov. 15 1948.

Immediate cause of death	DURATION
General Metastasis	6 mo
Due to: Carcinoma of Prostate	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M N Kleaveau, Md M. D. or other
Address: Annapolis Date signed: 11/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164C Registered No. 16096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Margaret's
(c) Hospital or institution: Anne Arundel Co., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town St. Margaret's
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA LEE GLICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jacob E. Glick
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1920

8. AGE: Years	Months	Days	If less than one day
28	3	8	hr. min.

9. Birthplace Mt. Carmel, Illinois
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Roy D. Short
13. Birthplace Indiana

MOTHER
14. Maiden Name ~~VERSA Fladval~~ FRAVEL
15. Birthplace Indiana

16 (a) Informant Jacob E. Glick
(b) Address St. Margaret's, A.A.Co., Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-16-48 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel, Illinois
Location

18 (a) Funeral director B. L. HOPPING & SON
(b) Address 170-172 West St., Annapolis

19 (a) Nov. 16 1948 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1948, at 2 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-15-48 at 12 Noon M.
(b) Where did injury occur? St. Margaret's, A.A.Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature [signature] M.D.
Medical Examiner.
Date signed 11-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS 151

11097

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years 2 mo 9 days

Hospital, institution, or street address where death occurred:

District Training School

How long in hospital or institution? 6 years 2 mo 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: D.C.

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 923 - 8th St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: William Buckner Green

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 24, 1936

8. AGE:

Years	Months	Days	If less than one day
12	5	14	____ hrs. ____ min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER

12. Name: Arthur B. Green

13. Birthplace: Washington, D.C.

MOTHER

14. Maiden name: Norma Fletcher

15. Birthplace: Washington, D.C.

16. Informant: D.T.S. records

Address: Laurel, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov. - 8 - 48 (month) (day) (year)

Cemetery or crematory: ____

Location: Washington, D.C.

18. Funeral director: W.W. Chambers Co.

Address: 517 - 11th ST. S.E., Wash. D.C.

19. Nov 8 19 48 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8 19 48 at 12 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 46, to Nov 8 19 48 and that I last saw h. l.m. alive on Nov 7 19 48

Immediate cause of death	DURATION
Bilateral bronchopneumonia	Nov 4, 1948
Due to	
Due to	
Other conditions pseudo hypertrophic muscular dystrophy, birth mental deficiency - imbecile	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op. ____

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of Injury ____ Injured at work?

23. SIGNATURE: J. A. Slaton, M.D. M. D. or other

Address: D.T.S. Laurel, Md. Date signed 11-8-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr Purves

11698

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 49 Franklin

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eugene T. Griffin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Annie Laurie Griffin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 15th 1859

8. AGE: Years	Months	Days	If less than one day
88	10	21	..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Pet Machinist at U.S.

11. Industry or business: Naval Academy Annapolis Md

FATHER

12. Name: Thomas Griffin

13. Birthplace: Maryland

MOTHER

14. Maiden name: Dallia Boyd

15. Birthplace: Maryland

16. Informant: Mrs Bertha M Jewell

Address: 49 Franklin St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-7-48 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Nov 7 1948 (Date rec'd by registrar) W. O. Franck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 5th 1948, at 12-10 A M

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from Oct 20 1948, to Nov 5 1948

and that I last saw him alive on Nov 5 1948

Immediate cause of death

Due to: Cerebral Hemorrhage with Hemiplegia left side

Due to: Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION
Several Days.
Since Oct 20 1948
Duration Yrs.

Major findings of operation: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Helen Purves M. D. or other

Address: Annapolis Md Date signed 11/6/48

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inc... is especially important. Physicians: please write the causes of death clearly and legibly.

~~CERTIFICATE OF BIRTH AND DEATH~~ DEATH 11093

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

(57C)

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County ANNE ARUNDEL

City or town ANNAPOLIS, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Length of mother's stay in County
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State FLORIDA

County ESCAMBIA

City or town PENSACOLA
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Second Street
(If RURAL give LOCATION)

3. Name of child Howard Laurence Grimmell III

4. Date of birth 2 November 1948 Hour 8:55 P. M.

5. Sex Male | 6. Twin or triplet --

7. No. of weeks pregnancy 38

FATHER OF CHILD

8. Full name Howard Laurence Grimmell Jr.

9. Color White 10. Age at time of this birth 30 yrs.

11. Usual occupation U.S. Navy

MOTHER OF CHILD

12. Full maiden name Dorothy Elizabeth Day

13. Color White 14. Age at time of this birth 27 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1

(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Polyhydramnios

19. Labor: (a) Complications of None

(b) Induced? Yes

20. (a) Was there an operation for delivery? No (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? No

During operation? No

21. Cause of ~~stillbirth~~ DEATH. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes ANENCEPHALUS

(b) Maternal causes None

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature George N. Schiff
(Specify if M. D., midwife, or other)

Address U.S. Naval Hospital, Annapolis, Md.

23. (a) Burial (b) Date thereof Nov 4th 1948
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Naval Academy

24. (a) Funeral director John M. Taylor Jr.

(b) Address Annapolis Md.

25. (a) Nov 3, 1948 (b) [illegible]
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

CHILD LIVED 22 Minutes
EXPIRED at 9:17 P.M. on 11-2-48

V. S. A10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11110
124 b
22
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A A

City or town Jessups Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two months

Hospital, Institution, or street address where death occurred:
Maryland House of Correction

How long in hospital or institution? 49 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A A

City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)

Street No. M H C
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME WILLIAM B. GRUBBS.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	widower

6.(b) Name of husband or wife Lena Funk

deceased 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1868

8. AGE: Years	Months	Days	If less than one day
79	10	22	—hrs. —min.

9. Birthplace Chesterfield, Va.
(Town, county, and state)

10. Usual occupation Huckster

11. Industry or business —

FATHER 12. Name Yewell GRUBBS

13. Birthplace Va.

MOTHER 14. Maiden name Belle WOOLRICH

15. Birthplace VA.

16. Informant M H C

Address Jessups Md.

17. Removal Date thereof 11-2-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakwood Mems

Location Richmond Va

18. Funeral director Wm J. Tiebout & Sons

Address North & Pennsylvania Balto Md

19. Nov 1 1948 Clara Rasin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1st, 1948, at 7:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1948 to Nov 1 1948 and that I last saw h.. alive on Nov 1 1948

Immediate cause of death	DURATION
Edema of lungs	
Due to Cirrhosis of Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thurston A. Clark M.D.
M. D. or other

Address Jessups Md Date signed 11/4/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e 11101

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ins correct age is especially important. Physicians: please write the causes of death clearly and concisely.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County ANNE ARUNDEL
City or town ANNAPOLIS, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
HOME 8 MONROE COURT
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ANNE ARUNDEL
City or town ANNAPOLIS, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 MONROE COURT
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME KENNETH LEON HAMMER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 15 April 1948

8. AGE:

Years	Months	Days	If less than one day
	6	6	..... hrs. ..... min.

9. Birthplace ANNAPOLIS, ANNE ARUNDEL, MARYLAND
(Town, county, and state)

10. Usual occupation CHILD

11. Industry or business

FATHER
12. Name Henry Hammer
13. Birthplace Krakow, Poland

MOTHER
14. Maiden name Helen Quitner
15. Birthplace Tarnow, Poland

16. Informant Henry Hammer
Address 8 Monroe Ct - ANNAPOLIS, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof NOV 21/48 (month) (day) (year)
Cemetery or crematory Kunkle Israel
Location 3 miles east
18. Funeral director B. L. Hopkins & Son
Address Annapolis, Md

19. Nov. 20 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 19 48, at 3 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Sept 1948, to 19 Nov 1948
and that I last saw h.. alive on 7 Sept 48 1948

Immediate cause of death	DURATION
Due to Congenital Heart	Life
Due to Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Felix Price M.D.
M. D. or other
Address 212 N. Loge St Annapolis Date signed Nov 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 11102

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne ARUNDEL
City or town 90 Charles St. Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A A.
City or town 90 Charles St. Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL WESLEY HARDESTY

3.(b) Social Security Number: 215-18-8592A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Edna WREXN Hardesty
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Oct 13 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
80	2	19		

9. Birthplace: Calvert Co. Md. (Town, county, and state)
10. Usual occupation: Retired.
11. Industry or business: Insurance

FATHER
12. Name: Unkown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Edna W. Hardesty
Address: 90 Charles St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 4, 1948 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Lothian Md.

18. Funeral director: T A Hardesty & Son
Address: Galesville, Md.

19. Nov. 3 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 2 1948 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Nov 2 1948 and that I last saw h. alive on Nov 2 1948

Immediate cause of death	DURATION
Acute Cardio-Vascular Failure	
Due to Coronary Thrombosis	2 or 3 Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Galesville Md. Date signed 11/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11103

Reg. Dist. No. 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural — Odenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural — Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Elizabeth Harrison

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	W.

6.(b) Name of husband or wife: Wesley Harrison
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1853

8. AGE: Years	Months	Days	If less than one day
95			..... hrs. ..... min.

9. Birthplace: A.A. Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Henson
FATHER 13. Birthplace
MOTHER 14. Maiden name: Susie Henson
MOTHER 15. Birthplace: A.A. Co. Md.
16. Informant: Ellen Sinclett
Address: Odenton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14 '48 (month) (day) (year)
Cemetery or crematory: Fork Church Cem.
Location: A.A. Co. Md.
18. Funeral director: W. Fladung Sons
Address: Bowie Md.
19. 11/13 19.. E. F. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12 19 48, at 11:25 A.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased~~ from ..... 19.. to ..... 19..
and that I last saw h... alive on ..... 19..

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Arteriosclerosis	
Due to: Cardiovascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Rittenhouse, M.D.
Acting M.E. Other
Address: Annapolis, Md. Date signed 11/12/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97 11104

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? four days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? four days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cec il
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 Center Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: MARGARET MONICA HENRY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: unknown (deceased)
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): December - 1875

8. AGE: Years	Months	Days	If less than one day
72	11	?	...hrs. ...min.

9. Birthplace: Port Deposit, Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24 1948 (month) (day) (year)
Cemetery or crematory: Jones Memorial Cemetery
Location: Port Deposit Rural, Maryland

18. Funeral director: Wm. A. Tattersall & Son
Address: Perryville, Md.

19. Mar 23 1948 (Date rec'd by registrar) E. J. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19, 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 15, 1948 to November 19, 1948 and that I last saw her alive on November 19, 1948

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
known to us since 11/15/48	
Due to	
Due to	
Other conditions: Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Carl Mongeuta M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 11/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11105

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 91

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 142 Market St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 142 Market St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ida Virginia Holland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Joseph Holland
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 25, 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	11	17		

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: George Thomas
13. Birthplace: Annapolis Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: William Holland
Address: 142 Market St. Annapolis Md

17. Burial (Burial, cremation, or removal — which?) Date thereof 11/20/48 (month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Annapolis Md.

18. Funeral director: John M. Payne
Address: Annapolis Maryland

19. Nov 20 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1948, at 2 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1948, to Nov 18 1948 and that I last saw h[illegible] alive on Nov 17 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	Nov 18
Left Hemiplegia	
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions: Hypostatic Pneumonia	unknown

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George A. Beard M. D. or other
Address: Annapolis Md Date signed 11-19-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 523 State St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1

3. (a) FULL NAME: Enoch Henry Howes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Laura Elizabeth Howes
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Aug. 18 1895

8. AGE: Years	Months	Days	If less than one day
53	3		10 hrs. min.

9. Birthplace: Churchton Md. (town, county, and state)
10. Usual occupation: Elevator Operator
11. Industry or business: U S Navy

FATHER
12. Name: John Henry Howes
13. Birthplace: Churchton, Md.

MOTHER
14. Maiden name: Orem
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Henry Monsen
Address: 1006 Jackson St, Eastport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 30, 1948 (month) (day) (year)
Cemetery or crematory: Woodfields
Location: Galesville, Md.

18. Funeral director: T.A. Hardesty & Son
Address: Galesville, Md.

19. Nov. 29 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1948, at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5, 1948, to Nov. 28 1948
and that I last saw him alive on Nov. 28, 1948

Immediate cause of death	DURATION
Bronchiogenic Carcinoma	1 yr.
Due to	
Due to	
Other conditions: Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jane R. Stanton, M.D.
M. D. or other
Address: Annapolis, Md. Date signed 11/29/48

11107

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred: Annapolis Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No. Saddle, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary A. Isaacs — Mary A.

3.(b) Social Security Number: None

4. Sex: female | 5. Color or race: negro | 6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 19, 1883

8. AGE: Years 65 | Months 4 | Days 4 | If less than one day: hrs. ___ min. ___

9. Birthplace: Hope Chapel A.A. Co. Md. (Town, county and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: William Henson
13. Birthplace: Calvert Co.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mary Alice Isaacs
Address: Parole, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 11-19-1948 (month) (day) (year)
Cemetery or crematory: Fowlers Cemetery
Location: Best Gate, Md.

18. Funeral director: Mrs. Charles E. Tuck (Lic.)
Address: 43-45 Northwest Street

19. November 18, 1948
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1948, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated: [redacted]
Postmortem Examination
at [redacted] Nov. 17 1948

Immediate cause of death	DURATION
Shock	4 days
Due to: Internal injuries abdominal	
Due to: Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident — Date of: 11-12-48
Where did injury occur? Parole (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place, (where?): at home
Means of injury: fell out 2nd Story window — Injured at work? yes

23. SIGNATURE: John M. Cuffy M.D. — Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. — Date signed: 11-17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

130 11108

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Earleigh Hgts. A. A. Co.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

at his residences in Earleigh Hgts.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Earleigh Hgts. Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. 1 Severna Park P. O.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: John Jefferies

3. (b) Social Security Number: 114-03-6154

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Carrie Thomas Jefferies

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 1881

8. AGE: Years	Months	Days	If less than one day
67	11		____ hrs. ____ min.

9. Birthplace: Blanch N. C. NorthCarolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER

12. Name: John Jefferies Sr.

13. Birthplace: Blanch NorthCarolina

MOTHER

14. Maiden name: Esther Pinchbach

15. Birthplace: North Carolina

16. Informant: [redacted] Carrie T. Jefferies

Address: Earleigh Hgts. Md. R.1 P. O. Servena Pkk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-16-48 (month) (day) (year)

Cemetery or crematory: Earleigh Heights, Cemetery

Location: Earleigh Hgts. A. A. Co. Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Nov 15 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1948, at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1948, to Nov 12 1948, and that I last saw h[redacted] alive on Nov 10 1948

Immediate cause of death	DURATION
Chr. Pulmonary Tuberculosis advanced.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: M. J. Kluwaya Md M. D. or other

Address: Annapolis Md Date signed 11/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 97

11109

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two years, 10 mos. 17 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? two years, 10 mos. 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ****

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: none
(If rural, give LOCATION)

2.(a) If veteran, name war: ***

3. (a) FULL NAME

DANIEL JOHNSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	widowed

6.(b) Name of husband or wife: *****

6.(c) If alive, give age: ** years

7. Birth date of deceased (mo., day, yr.): 1890 ?

8. AGE: Years	Months	Days	If less than one day
58 ?	?	?	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER — 12. Name: ****

FATHER — 13. Birthplace: ****

MOTHER — 14. Maiden name: Rebecca Johnson

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/1/48

Cemetery or crematory: Arbutus Memorial Pk, Inc

Location: Md.

18. Funeral director: George G. Kelson

Address: 1303 Presstman St.

19. December 19 48 (Date rec'd by registrar) R. W. Pedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 19 48 at 2:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11, 1946 1946 to November 28 19 48 and that I last saw him alive on Nov. 28 19 48

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	
known to us since	Jan. 11
Due to	1946
Due to	
Other conditions: Senile Psychosis	
Simple Deterioration	

(Include pregnancy within 3 months of death)

Major findings of operations: **** Date of op.: ****

Autopsy results: ****

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: **** Date of: ****

Where did injury occur? **** (City or town) **** (County) **** (State)

Injured at home, farm, industry, public place (where?): ****

Means of injury: **** Injured at work? ****

23. SIGNATURE: Jacob Mongaster M.D. M. D. or other

Address: Crownsville, Md. Date signed: 11/29/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give the correct age if is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11110

83a

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 201-7th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Winfree D. Johnsen

3.(b) Social Security Number: 218-09-3258

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Florence A. Johnsen

6.(c) If wife, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 9, 1864

8. AGE: Years	Months	Days	If less than one day
84	8	13	....hrs. ....min.

9. Birthplace: Ga. (Town, county, and state)

10. Usual occupation: Stationary Engineer

11. Industry or business: National Distillers

FATHER — 12. Name: Johnsen

FATHER — 13. Birthplace: Don't know

MOTHER — 14. Maiden name: Don't know

MOTHER — 15. Birthplace: Don't know

16. Informant: Howard D. Johnsen

Address: 201-7 th Ave Brooklyn Pk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 24, 1948 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: G. Howard Evans

18. Funeral director: H & H Co 1 E Chase St

Address

19. Nov 23 1948 (Date rec'd by registrar) A W Heckrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 21, 1948, at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 48 to Nov 21 19 48 and that I last saw h.. alive on Nov. 21 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Denis J. McGrath M. D. or other

Address: 1 E. Randall Ave Date signed: 11/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1111

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years 15 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or Institution? 4 years 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ———

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 W. 23rd Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ***

3. (a) FULL NAME: AMY JONES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Bennie Jones

6.(c) If alive, give age: *** years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years: 46 Months: -- Days: -- If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: none

FATHER — 12. Name: Billy Hollaman

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: *****

MOTHER — 15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. (Burial, cremation, or removal. Where?) burial Date thereof: 12/10-48 (month) (day) (year)

Cemetery or crematory: Hardelat

Location: Crownsville Md

18. Funeral director: Capt Hospital

Address: Crownsville Md

19. (Date rec'd by registrar) 12/10 48 C. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28, 1948 at 9:40PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 13 1944 to Nov. 28 1948 and that I last saw her alive on Nov. 28 1948

Immediate cause of death: General Paresis — DURATION: 11/13/44

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ****

Date of op. ***

Autopsy results: ****

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: **** Date of ***

Where did injury occur? *** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ***

Means of injury: **** Injured at work? ****

23. SIGNATURE: Jacob Almquist M.D. M. D. or other

Address: Crownsville, Md. Date signed: 11/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 11112

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 21 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington, (Little Sisters of the Poor)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: H & 3rd Sts., N.W.

(If rurol, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

EDWARD JONES (ALIAS JERRY)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: -----

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Unknown - About 1888

8. AGE: Years	Months	Days	If less than one day
60?			....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER — 12. Name: Thomas Jones

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sophie Lee

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 11/18-48 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18 Funeral director: Supt.

Address: Crownsville Md

19. (Date rec'd by registrar) 11/18 1948 E. F. Jones Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1948, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11, 1927 to November 11, 1948 and that I last saw him alive on November 11, 1948

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Known to us since	11/11/27
Due to:	
Due to:	
Other conditions: Psychosis with Mental	
Deficiency known to us since	11/11/27

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.: -------

Autopsy results: -pp-

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: -------

Where did injury occur? -------- (City or town) ------ (County) (State)

Injured at home, farm, industry, public place (where?): --------

Means of injury: -------- Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville, Md. Date signed 11/11/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 11113

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 109 Lafayette Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Bertha E. Klakring

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Leslie L. Klakring
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 30th 1884

8. AGE:

Years	Months	Days	If less than one day
64	1	7	____ hrs. ____ min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:

FATHER
12. Name: Thomas Basil
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Mary E. Basil
15. Birthplace: Annapolis Md.

16. Informant: Leslie L. Klakring
Address: 109 Lafayette Ave Annapolis Md.
17. Burial
(Burial, cremation, or removal. Which?) Date thereof 11-9-48 (month) (day) (year)
Cemetery or crematory: Naval Academy
Location: Annapolis Md.
18. Funeral director: John M. Layton Son
Address: Annapolis Md.
19. Nov. 9 1948
(Date rec'd by registrar)
W. [illegible]
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 7 1948 at 6 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948 to Nov 7 1948 and that I last saw her alive on Nov 6 1948

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency Chr.	Unknown
Due to: Hypertension	Several years
Due to:	
Other conditions: Chr. Interstitial Nephritis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Leroy E. Basil M. D. or other
Address: Annapolis Md. Date signed 11-8-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 11114

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel

County

City or town Severn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Severn (If outside city or town limits, write RURAL and give nearest town)

Street No. Telegraph Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Pauline Augusta Lehner

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	married

6.(b) Name of husband or wife August J. Lehner 6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 7, 1880

8. AGE: Years	Months	Days	If less than one day
68	7	13	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John A. Fox

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Christine Zeun

15. Birthplace Germany

16. Informant Mr. August Lehner

Address Severn P. O., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/23/48 (month) (day) (year)

Cemetery or crematory Glen Haven Cem.

Location Glen Burnie, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Nov 22 19 48 A. W. Bedsworth Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20-48 19 ... at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5 48 to Nov 20-48 19 ... and that I last saw h[illegible] alive on Nov 19 - 19 48

Immediate cause of death

(a) Lobar Pneumonia — DURATION 1 day

Due to

Due to

Other conditions Senility Cerebral Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Odenton Md Date signed Nov 20-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13a 11115

Reg. Dist. No. 21

1. PLACE OF DEATH

County A. A. Co.

City or town Jacobsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Jacobsville (If outside city or town limits, write RURAL and give nearest town)

Street No. Fort Smallwood Rd. Route #3 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Bruce Mackenzie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced.

6.(b) Name of husband or wife Annie M. MacKenzie 6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1872

8. AGE: Years 76 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Barber, Retired.

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden name ?

15. Birthplace ?

16. Informant Harry E. MacKenzie.

Address Fort Smallwood Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 26 1948 (month) (day) (year)

Cemetery or crematory Druid Ridge.

Location Pikesville.

18. Funeral director Paul E. Schemmel & Jr.

Address 3615-17 Chestnut Ave.

19. Nov 24 1948 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23, 1948 about 4:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I ~~attended deceased from~~ did not attend him 19 ... to ... 19 ... and that I ~~last saw him~~ did not see alive on ... 19 ...

Immediate cause of death	DURATION
Myocardial failure - acute.	
Due to Hypertensive cardio-vascular Disease; Chronic Glomerulo-nephritis	14 yr 6 mos
Due to Generalized arteriosclerosis	Indefinite
Other conditions None.	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE A. F. Gadaas M.D. M. D. or other

Address Green Gables - Pasadena, Md. Date signed 11/23/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11116

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age in years, months, days, hours, minutes, where necessary. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County A. A. Co.
City or town Hanover, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Hanover, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, gives LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Agnes A. Makinson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	single

6.(b) Name of husband or wife -
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1873

8. AGE: Years	Months	Days	If less than one day
75	0	20	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Daniel Makinson
13. Birthplace Baltimore, Md

MOTHER
14. Maiden name Caroline Johanes
15. Birthplace Baltimore, Md.

16. Informant Mrs. Roland R. Ray
Address Harmons, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/17/48 (month) (day) (year)
Cemetery or crematory Western Cem.
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 11/15 (Date rec'd by registrar) 19 48 Alw Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14th 1948, at 6:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4th 1948, to Nov. 14th 1948, and that I last saw h[illegible] alive on Nov. 13th 1948

Immediate cause of death	DURATION
Coronary Thrombosis -	9 mos.
Due to Hypertensive Cardio-Vascular Disease -	3 yrs.
Due to arterio-sclerosis -	?
Other conditions Hepatitis - (Include pregnancy within 3 months of death)	5 days.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.
M. D. or other
Address Savage, Md. Date signed 11/14/48

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 71c

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... Churchton, Maryland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) ..... Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... Md. (b) County ..... Anne Arundel
(c) City or town ..... Deale
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME ..... LEONARD ..... MANIFOLD

3 (b) If veteran, name war .....

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ABT. 1902

8. AGE: Years	Months	Days	If less than one day
46			..... hr. ..... min.

9. Birthplace ..... Deale, Anne Arundel, Md.
(Town, county, and state)

10. Usual Occupation ..... Boat builder

11. Industry or business .....

FATHER
12. Name ..... Andrew Manifold
13. Birthplace ..... Deale, Anne Arundel Co., Md.

MOTHER
14. Maiden Name ..... Ida ?
15. Birthplace ..... Deale, Anne ARundel Co., Md.

16 (a) Informant ..... Bernard Hardesty
(b) Address ..... Galesville, Maryland

17 (a) ..... Burial ..... (b) Date thereof 11-17-48
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ..... St. James
Location ..... Tracey's, Maryland

18 (a) Funeral director ..... HARDESTY FUNERAL HOME
(b) Address ..... Galesville, Maryland

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... November 14 ..... 19 48, at 11 A M

21. I certify that I took charge of the remains described above, held an ..... Autopsy ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy Inspection or Inquiry, find that said deceased came to ..... his ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH .....
Cerebral edema
due to Acute alcoholism.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature ..... Medical Examiner. ..... M.D.

Date signed 11-15-48

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11117

164C

CERTIFICATE OF DEATH

Reg. Diat. No. 27

1. PLACE OF DEATH:
County Anne Arundel
City or town Fort George G Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County
City or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME ROBERT J. MASON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 29 July 1920

8. AGE: Years	Months	Days	If less than one day
28	3	14	hrs. min.

9. Birthplace Boston, Massachusetts
(Town, county, and state)
10. Usual occupation Soldier
11. Industry or business

FATHER
12. Name R. Page Mason
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Service Records
Address U.S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12 November 48 (month) (day) (year)
Cemetery or crematory Unknown
Location Philadelphia, Pa.

18. Funeral director Lilly & Zeiler Inc
Address Baltimore, Maryland

19. 12 Nov 19 48 James N. Goerger, Capt. MSC
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 November 19 48 at 1650 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from viewed the deceased 19 to 19
and that I last saw him alive on 12 November 19 48

Immediate cause of death	DURATION
Wound, penetrating, gunshot, .45 cal., point of entrance 3d interspace, left anterior chest	Instant
Due to 7 cm from mid sternal bone.	
Due to hemorrhage into left pleural cavity.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results See Reverse Side

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Suicide Date of 11/12/48
Where did injury occur? Ft. Meade (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Army Post
Means of injury Gunshot Wound Injured at work? No

23. SIGNATURE David R. Metcalf, Capt M.C.
DAVID R METCALF, Capt., M.C.
M. D. or other
Address Ft eo G Meade, Md. Date signed 15 Nov 48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

AUTOPSY RESULTS:

MISSLE TRACT TRAVERSING LEFT ANTERIOR CHEST WALL, LEFT PLEURA, PERICARDIUM, LEFT VENTRICLE OF HEART, LEFT LUNG AND LEFT POSTERIOR CHEST WALL.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

11118

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town South Down Lake Nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1208 Bay Ridge Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war W.W. II

3.(a) FULL NAME: CHARLES HENRI MASTERS

3.(b) Social Security Number: 216-16-4028

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorita Watson Masters
6.(c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.): June 19, 1921

8. AGE:

Years	Months	Days	If less than one day
27	4	26	hrs. min.

9. Birthplace: Eastport A.A. Co., Maryland
(Town, county, and state)
10. Usual occupation: Inspector
11. Industry or business: Tidewater Fisheries Commission St. of Maryland

FATHER
12. Name: Dr. George Waylor Masters
13. Birthplace: La.

MOTHER
14. Maiden name: Henrietta Windsor
15. Birthplace: Annapolis, Maryland

16. Informant: George W. Masters (Brother)
Address: 1208 Bay Ridge Ave. Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-18-48 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. Nov 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination Nov. 15, 1948

Immediate cause of death	DURATION
Fracture of Skull	
Due to: Hemorrhage	
Due to:	
Other conditions: Rt. ankle almost completely severed at joint	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Nov. 15, 1948
Where did injury occur? (City or town) near Rowa Bradds Cove (County) A.A. (State) Maryland
Injured at home, farm, industry, public place (where?) South River
Means of injury: Air plane crash Injured at work? Yes

23. SIGNATURE: John M. Catley, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 11-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c 11119

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH

County: Anne Arundel

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County:

City or town: Alexandria

(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 No. Payne

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME Edward T. Mitchell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	married

6.(b) Name of husband or wife: Virginia Mitchell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 12 1908

8. AGE:

Years	Months	Days	If less than one day
40	9	15	hrs. min.

9. Birthplace: Cedar Hill Brooklyn A.A.Co., Md. (Town, county, and State)

10. Usual occupation: Warehouse Foreman

11. Industry or business: Ordnance U.S. Army

FATHER — 12. Name: Edward T. Mitchell

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Margery L. Williams

MOTHER — 15. Birthplace: Cedar Hill A.A.Co. Maryland

16. Informant: Margery L. Mitchell

Address: 308 Cedar Hill Lane, Baltimore 25 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-1-48 (month) (day) (year)

Cemetery or crematory: Mount Calvary Cem.

Location: A. A. Co.

18. Funeral director: Charles L. Lane

Address: 802 Madison ave

19. Nov. 29 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1948 at 8:30 P.M.

21. I CERTIFY, that death occurred on the date above stated, ~~that I attended deceased from~~ Post Mortem Examination 19..... ~~and that I last saw him alive on~~ Nov. 27 1948

Immediate cause of death	DURATION
Due to: Acute Dilatation of Heart	sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claff M.D. Medical Examiner (M. D. or other)

Address: Annapolis Md Date signed 11-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

FILM No. G 11 DEC - 8 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11120

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? DOA
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? DOA

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #1
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: JOSEPH HENRY NOTHEY

3.(b) Social Security Number: 578-12-8634

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie L. Nothey
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): August 3, 1916

8. AGE: Years	Months	Days	If less than one day
32 ~~33~~	3	26	....hrs. ....min.

9. Birthplace: Leeland, Maryland (Town, county, and state)
10. Usual occupation: Car Salesman
11. Industry or business: Automobile

FATHER
12. Name: James H. Nothey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose Mary Bell
15. Birthplace: Maryland

16. Informant: Mrs Carrie L. Nothey
Address: RFD #1 Riva Rd Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 2, 1948 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland
19. Nov. 30 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29, 1948 at 4 05 P.M.

21. I CERTIFY that death occurred on the date above stated. ~~Medical Examiner~~ Post mortem Examiner
~~and that I last saw him alive on~~ Nov. 29 1948.

	DURATION
Immediate cause of death: Hemorrhage from lungs	Sudden
Due to:	
Due to: Pulmonary tuberculosis unknown	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ....
Means of injury: ....Injured at work? ....

23. SIGNATURE: John M. Clarke M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 11-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

182 11121

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrivee
Hospital, Institution, or street address where death occurred: Annapolis Hospital
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: near Priests Bridge
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Linda Louise Parks

3.(b) Social Security Number:

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: —
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 9. 1948
8. AGE: Years: | Months: 2 | Days: 5 | If less than one day: hrs. min.
9. Birthplace: Annapolis A.A. Co, Maryland (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: Garland Parks
13. Birthplace: Sugar Grove, Va

MOTHER
14. Maiden name: Mildred Caudell
15. Birthplace: Virginia

16. Informant: Garland Parks
Address: Gambrills, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: November 15, 48 (month) (day) (year)
Cemetery or crematory:
Location: Rural Retreat, Virginia
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland
19. Nov. 15, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14, 1948 at 10 00 p. M

21. I CERTIFY that death occurred on the date above stated [illegible] Post mortem Examination Nov. 14, 1948

DURATION

Immediate cause of death: Suffocation
Due to: Accidental
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Nov. 14. 1948
Where did injury occur? Gambrills (City or town) P.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury: suffocation Injured at work? —

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md. Date signed: 11-14-48

M

I

T

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 11122

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severn, Md., R.F.D. Box 171D
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:
Stevenson's Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn, Md., R.F.D. Box 171D
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stevensons Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Morris Richard Parrish

3. (b) Social Security Number: 213-20-6528

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 1, 1897

8. AGE:

Years	Months	Days	If less than one day
51	8	4	hrs. min.

9. Birthplace: Scaggsville, Howard Co., Md.
(Town, county, and state)

10. Usual occupation: Millworker (ret.)

11. Industry or business:

FATHER
12. Name: Morris Stanley Parrish
13. Birthplace: Dickiesville, Howard Co., Md.

MOTHER
14. Maiden name: Anna Day
15. Birthplace: Howard Co., Md.

16. Informant: Mrs. Clara Parrish
Address: Severn, Md., R.F.D. BOX 171D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Maryland

19. Nov 6, 1948 (Date rec'd by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4, 1948 at 4:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: CORONARY THROMBOSIS	
Due to: ARTERIOSCLEROSIS	
Due to: UNKNOWN.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry F. Langan, M.D.
M. D. or other

Address: Glen Burnie, Md. Date signed: 11/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159 11123

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital Annapolis
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Sudley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) —
2.(a) If veteran, name war

3.(a) FULL NAME ALBERT James Poland.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): NOV 13 1948

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Annapolis A. A. Co Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Joseph A. Poland.
13. Birthplace: Lubec, Allegany Co. Md.

MOTHER — 14. Maiden name: Evelyn Lease
15. Birthplace: Crellsptown, Allegany Co. Md

16. Informant: Joseph A. Poland
Address: Sudley Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Nov. 16 1948 (month) (day) (year)
Cemetery or crematory: Quaker Cem
Location: Galesville Md.
18. Funeral director: E. A. Hardesty & Son
Address: Galesville Md.

19. Nov. 16 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV 15 19 48 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 19 48 to Nov. 16 19 48 and that I last saw him alive on Nov. 15 19 48

Immediate cause of death	DURATION
prematurity -	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily N. Wilson, M.D. M. D. or other
Address: Lothian, Md. Date signed 11/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122b

11124

20

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County... Anne Arundel

City or town... Rural Hanwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street addreee whero death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residenee of mother)

State... Maryland County... Anne Arundel

City or town... Rdsale, Hanwood Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME George Albert Randell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widow

6.(b) Name of hueband or wife... Alice Randall

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) May 26, 1862

8. AGE: Yeare	Months	Days	If lese than ono day
86	5	9	...hre. ...min.

9. Birthplace... A. A. Co. Hanwood md.

(Town, county, and state)

10. Ueual occupation... Farmer

11. Industry or busineee

FATHER 12. Name... Stephen Randall

13. Birthplace A. A. Co.

MOTHER 14. Malden name... Elizabeth Jones

15. Birthplace Md.

16. Informant... Synthia Jones.

Address Hanwood, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7 1948 (month) (day) (year)

Cemetery or crematory... Cherry Chapel

Location... Hanwood, Md.

18. Funeral director... J. B. Johnson

Address 34 Lafayette Ave. Annapolis Md.

19. Nov. 7, 1948 (Date rec'd by registrar) W. R. Boyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... November 4, 1948 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceaeed from Nov 2 1948 to Nov 4 1948

and that I last saw h... alive on Nov 3 1948

Immediate cause of death... Valvular Obstruction — DURATION

Due to.....

Due to.....

Due to.....

Other conditions.....

(Include pregnaney within 3 months of death)

Major fiediers of operatioes.....

Date of op.....

Autepsy results.....

PHYSICIAN: Please nederline the cause te which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, euicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Meane of injury ..... Injured at work?

23. SIGNATURE... C. T. Allen M.D. M. D. or other

Address 10 Conrad Date signed 11-6-48

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 11125

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years.

Hospital, institution, or street address (where) death occurred: Oakwood Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: N. Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hampton Road.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sallie Eakin Ripley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow.

6.(b) Name of husband or wife: Henry C. Ripley. (Dead) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January-9-1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	9	22		

9. Birthplace: Craig County-Virginia (Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER — 12. Name: John Eakin

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Caldwell

15. Birthplace: Virginia

16. Informant: Mrs. Pauline Ripley (daughter)

Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1948 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Baltimore

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Nov 3 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1, 1948 at 10 4th A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__

and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Garland A. Parker, M.D. (Informant, physician, Coroner) M. D. or other

Address: Glen Burnie, Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

11126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
Cedar Crest Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore,
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1207 - E. Hoffman St.
(If rural, give LOCATION)

2.(a) If veteran, name war: SPANISH-AMERICAN W.V.

3.(a) FULL NAME: Eva K. Ritt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: Eugene Ritt

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): October 9 - 1881

8. AGE: Years: 67 | Months: 1 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: [redacted], N. Y. CHESTER
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: James E. Conklin
13. Birthplace: New York State CHESTER

MOTHER
14. Maiden name: Unknown
15. Birthplace: CHESTER N. Y.

16. Informant: Cedar Crst. H. Home-Records
Address: Severna Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 29 1948 (month) (day) (year)
Cemetery or crematory: BAL. NATIONAL CEMETERY
Location: 5501 FREDERICK RD. BAL. MD

18. Funeral director: Frank Dellahoee
Address: 322 S. HIGH ST.

19. Nov 29 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1948 at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 11/1/48 19 to 11/26/48 19 and that I last saw h alive on 11/23/48 19

Immediate cause of death	DURATION
Pulmonary edema -	3 days
Due to: Carcinoma of Intestinal tract - (location unknown)	?
Other conditions: Hemorrhoids -	?

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Glen Burnie, Md. Date signed: 11/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Bc 97 11127

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos. 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1731 Ashland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME: EDWARD SANDERS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	widowed

6.(b) Name of husband or wife: -----
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years: 55 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ----

FATHER
12. Name: Unknown
13. Birthplace: ----

MOTHER
14. Maiden name: Unknown
15. Birthplace: -----

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/15/48 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt of Hospital.
Address: Crownsville Md

19. 11/15 1948 E.T. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1948, at 4:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1948 to November 10 1948 and that I last saw him alive on November 10 1948

Immediate cause of death: General Arteriosclerosis known to us since — DURATION: 7/29/48

Due to:

Due to:

Other conditions: Psychosis with Cerebral Arteriosclerosis - known to us since 7/29/48
(Include pregnancy within 3 months of death)

Major findings of operations: -----

----- Date of op.: -----

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: -----
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -----
Means of injury: ----- Injured at work?

23. SIGNATURE: Jacob Mayer M.D.
M. D. or other
Address: Crownsville, Md. Date signed: 11/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

MD. STATE

~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monroe Circle, Glen Burnie
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 4th Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HARRY WOOD SHELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Virginia Shell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1903

8. AGE: Years	Months	Days	If less than one day
45	4	21	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Boiler Engineer
11. Industry or business Consol. Gas. & Elec. Co.

FATHER
12. Name Harry Shell
13. Birthplace South Carolina

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Margaret V. Shell
(b) Address 106 - 4th Ave. South, Glenburnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-48 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location A. A. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

19 (a) 11-18-48 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1948, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Medical Examiner. M.D.
Date signed 11-17-48

VS 151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47d

11129

Reg. Dist. No. 20

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Rural - Bristol, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: P.G.

City or town: Rural - Bristol, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 mi East

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Oron Elgin Herbert

3. (b) Social Security Number: 212-16-8312

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eva Gertrude Herbert

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept 26, 1885

8. AGE:

Years	Months	Days	If less than one day
63	1	14	..... hrs. ..... min.

9. Birthplace: Mc Kendree, A. A. Co., Md

(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER

12. Name: John W. Herbert

13. Birthplace: Prospect Ldg, Md

MOTHER

14. Maiden name: Anna Crosby

15. Birthplace: York

16. Informant: Elsie S. Wanson

Address: Jewell, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14, 1948 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Lothian R.F.D., Md.

19. Funeral director: Ritchie Bros.

Address: Upper Marlboro, Md

19. 11/12 19 48 M. L. Clayton Registrar

(Date rec'd by registrar)

Dep Reg

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 November 1948, at 5:39 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 Octo 1948, to 11 Nov 1948 and that I last saw h.l.m. alive on 11 Nov 1948

Immediate cause of death	DURATION
Cerebral Coll apse	2 hrs
Due to Carcinoma Left Lung	1½ yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Inoperable Carcinoma

Date of op. 22 - Sept 48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. B. Lasner M.D. M. D. or Other

Address: Upper Marlboro, Md Date signed: 11 Nov 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 11130

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park - R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Cedar Crest Nursing Home

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Millersville, Ft. Meade Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: VIRGINIA C. STEVENSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Com. Charles W. Stevenson

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 8, 1879

8. AGE: Years	Months	Days	If less than one day
69	4	12	...hrs. ...min.

9. Birthplace: New York, N.Y.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Andrew Canfield
13. Birthplace: New York, N.Y.

MOTHER
14. Maiden name: Emily Groce
15. Birthplace: Philadelphia, Pa.

16. Informant: Mrs. T. L. Terrant
Address: 2915 Conneticut Ave., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 23, 1948 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Maryland

19. Nov 22 1948 (Date rec'd by registrar) L. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20 1948 at 2:47 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 1946, to Nov 20 1948, and that I last saw h..ex..alive on Nov 19 1948

Immediate cause of death	DURATION
Multiple Sclerosis	10 years
Due to	
Due to	
Other conditions: Diabetes Mellitus	10 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward J. Hewitt M.D.
M. D. or other

Address: Gambrills Md Date signed: Nov 22 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9-A-a 11131

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, Institution, or street address where death occurred:

438 N. Crain Highway

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 438 Crain Highway N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Charles F. Strickland

3.(b) Social Security Number 705 10 0807

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Edna M. Strickland (Nee Lowman) 6.(c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) January 8, 1903

8. AGE: Years	Months	Days	If less than one day
45	10	4	.....hrs. .....min.

9. Birthplace: Baltimore (Pimlico) Md.
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: Baltimore & Ohio Railroad.

FATHER — 12. Name: William Richard Strickland

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emily Stienaker

15. Birthplace: Maryland

16. Informant: Mrs. Edna Strickland

Address: 438-2Nd Ave. N.W. Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven Cemetery

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Nov 15 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 12, 1948 at 8 00 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~attended~~ Post Mortem Examination from ~~attendance~~ Nov. 12, 1948

Immediate cause of death	DURATION
Coronary occlusion	sudden
Due to:	
Due to: Coronary sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Cleffy M.D. Deputy Medical Examiner

M. D. or Other

Address: Annapolis, Md. Date signed 11-12-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 11132

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 53 Fleet St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Mr. Carl L. Swenson

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Catherine A Swenson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 8, 1885
8. AGE: Years 63 Months 5 Days 12 If less than one day ..... hrs. ..... min.
9. Birthplace Wisconsin (Town, county, and state)
10. Usual occupation Pipe fitter U.S. Naval Academy
11. Industry or business Retired
FATHER 12. Name August Swenson
13. Birthplace Sweedon
MOTHER 14. Maiden name —
15. Birthplace —
16. Informant Catherine A. Swenson
Address 53 Fleet St. Annapolis, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 48 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md.
18. Funeral director John M. Taylor-Son
Address Annapolis Md.
19. Nov. 19 19 48 (Date rec'd by registrar) Wm. T. French Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 19 48 at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 16 - 7 PM 19 48 to Nov 16 - 9 PM 19 48
and that I last saw him alive on Nov 16 19 48

	DURATION
Immediate cause of death: Coronary Thrombosis	few hrs.
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions: Myocarditis Chr.	unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE George C Boarman M. D. or other
Address Annapolis Md. Date signed 11-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c 11133

Reg. Dist. No. 21

M

1. PLACE OF DEATH
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 hours 75 minutes
Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution? 13 hours 75 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For a child born infant, give residence of mother)
State Maryland County Anne Arundel
City or town Churchton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Selena Thompson

3.(b) Social Security Number

4. Sex: female
5. Color or race: negro
6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 1. 1888

8. AGE: Years 60 Months 5 Days 16 If less than one day ... hrs. ... min.

9. Birthplace: Churchton A.A.Co., Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Garraway Holland
13. Birthplace: Churchton Md

MOTHER
14. Maiden name: not Known
15. Birthplace

16. Informant: Marcellus Thompson
Address 1127 - 3rd. N.E. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20. 1948 (month) (day) (year)
Cemetery or crematory Franklin Cem
Location Churchton Md
18. Funeral director H. C. Hardesty & Son
Address Galesville Md

19. November 18 1948 (Date rec'd by registrar)
W. J. Brooks Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1948 at 5:20 A M

21. I CERTIFY that death occurred on the date above stated: [redacted] from
Postmortem Examination to
[redacted] Nov. 17 1948

	DURATION
Immediate cause of death: Shock	
Due to: Internal injuries abdominal	
Due to: Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11-16-48
Where did injury occur? Churchton (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Main Hghy Churchton
Means of injury automobile struck her Injured at work? no

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis Md Date signed 11-17-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age, is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

30d 11134

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Fort Meade Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Fort Meade
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ennie Edna Tipton

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: John V. Tipton
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 24, 1916

8. AGE:

Years	Months	Days	If less than one day
32	3	17	... hrs. ... min.

9. Birthplace: Union Town, Alabama (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Bert McGuinns
13. Birthplace: Mississippi

MOTHER
14. Maiden name: Minnie Combs
15. Birthplace: Mississippi

16. Informant: Sgt. John V. Tipton
Address: Fort Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14, 1945 (month) (day) (year)
Cemetery or crematory: Riverdale Cemetery
Location: Columbus, Georgia

18. Funeral director: DeWitt Daniel Sons
Address: Laurel, Maryland James N. Goerger

19. 12 Nov 19 48 (Date rec'd by registrar) JAMES. N. GOERGER, Capt., MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1945, at 4:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Nov 19 45, to 10 Nov 19 45
and that I last saw h.e.r. alive on 10 Nov 19 45

	DURATION
Immediate cause of death: H. Jacobs Cpl MC Myocardial Infarction secondary to	Instant
Due to: Coronary Occlusion	Instant
Due to: Stenosis of Coronary Ostia	4 years
Due to: Luetic Aortitis (Syphilitic Aortitis) Un Known	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: Autopsy Refused
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Merlin E. Woesner M.D. Capt. M.C. A.U.S. (M. D. or other)
Address: Fort George G. Meade, Md. Date signed: 12 Nov '45